A for Effort

Making the Grade in Oral Health

An Oral Health America Special Grading Project

February 2005

ORAL HEALTH AMERICA
LEADING THE WAY TO A HEALTHY FUTURE

Campaign for Oral Health Parity

Funded in part by the W.K. Kellogg Foundation

[E]fforts to achieve acceptance of the intrinsic importance of oral health and its interdependence with general health must be directed to medical practitioners and other health professionals and researchers, as well as to educators, policymakers, and the general public.[3]

Overview

There are new efforts underway that show promise of brightening the nation's smile. Innovative initiatives now taking place at the state and local level show a positive focus being placed on oral health. Such *A for Effort* actions are models for the rest of the nation to follow and are recognized in this report.

Between 2001 and 2003, Oral Health America authored three consecutive state-by-state report cards that showed stalled national progress in advancing oral health parity. Grades of C, D, and even F were all too common. Health indicators in many states remain unacceptably low. Too few Americans receive regular oral health care. Too few dentists serve the neediest areas. Fluoridation of public water supplies is still below desirable levels in many states. While it will take years to improve individual grades from previous report cards, it is critical to recognize efforts now underway that are making a difference. These models will ultimately give the nation a straight A report card in oral health.

This report card awards nine *A for Effort* grades to Arkansas, California, Illinois, New Jersey, New Mexico, New York, South Carolina, and Washington. Six states also receive extra credit grades for making important strides in key areas. The grades recognize new programs, policies, and progress all reinforcing the message that oral health is essential to overall good health.

Under the leadership of two U.S. Surgeons General, increased attention has been given to oral health. The release of the Surgeon General's landmark 2000 report *Oral Health in America*[1] prompted Oral Health America's first national report card as a way to measure progress, and the following report cards to help ensure accountability. Three years later, the Surgeon General's office released the *National Call to Action to Promote Oral Health,*[2] providing the framework for this *A for Effort* report. The *Call to Action* defines five action steps toward improving oral health.

The fact remains: not all Americans are benefiting from improvements in health and health care, and that fact is no more evident than in oral health. Americans with minimal amounts of public or private health insurance often lack any oral health insurance. Many simply cannot afford to pay out of pocket for needed services. Access to care poses another problem—shortages of dental care providers, especially in rural and inner city areas, can make finding care a real difficulty.

However, findings of the Surgeon General's *Oral Health in America*, and new information that associates oral health with overall health, and oral disease with systemic diseases such as diabetes, stroke, pneumonia, heart disease and pre-term births, is bringing oral health to the attention of policymakers, opinion leaders, and the public as never before.

1 http://www.nidcr.nih.gov/NewsAndReports/ReportsPresentation/CallToPromoteOralHealth.htm. U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

2 http://www.surgeongeneral.gov/topics/oralhealth/. U.S. Department of Health and Human Services. *A National Call to Action to Promote Oral Health*. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service, Centers for Disease Control and Prevention and the National Institutes of Health, National Institute of Dental and Craniofacial Research. NIH Publication No. 03-5303, May 2003.

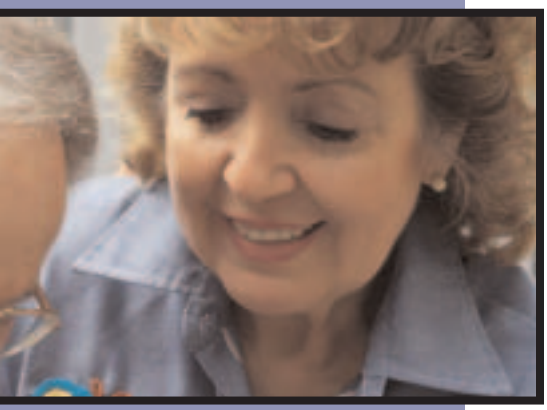
3 DHHS, A National Call to Action to Promote Oral Health.

About this Report

A for Effort focuses on efforts that are advancing one or more of the five action steps outlined in the U.S. Surgeon General's *National Call to Action to Promote Oral Health*. Defined by oral health leaders as key elements to sustained national improvements in oral health, these action steps are seen as guideposts for program directors, advocates, leaders, funders, health officials, and others, and thus seemed a natural key in awarding "A" grades.

Call to Action Steps	"A" States	Extra credit
Action 1: Change Perceptions of Oral Health	Illinois South Carolina	Vermont
Action 2: Overcome Barriers by Replicating Effective Programs and Proven Efforts	California	New Hampshire Utah
Action 3: Build the Science Base and Accelerate Science Transfer	Washington	United States Army
Action 4: Increase Oral Health Workforce Diversity, Capacity, and Flexibility	California	Alaska
Action 5: Increase Collaborations	Arkansas New Jersey New Mexico New York	Nevada West Virginia

A for Effort is not an attempt to grade the status of the nation's oral health. Oral Health America's previous report cards documented that the nation's overall oral health is locked in a state of mediocrity. Large sections of the nation face a growing oral health cavity and are not receiving proper or preventive care. This report card is designed to recognize promising efforts that provide innovation to break through the stagnation of progress and provide models that—if supported—have the potential to boost the nation's overall grade in future years.



Methodology

This document particularly acknowledges noteworthy state strategies launched since the release of the *Call to Action* and the last Oral Health America report card. "A" grades are awarded to a number of states taking bold steps to increase the profile of oral health, and reduce disparities for vulnerable populations including poor children, older Americans, and many members of racial and ethnic minorities.

In gathering information about compelling programs across the country, Oral Health America sought input from state dental health programs, foundations, national program offices, industry executives, and oral health leaders in areas such as fluoridation, Medicaid, public policy, research, communications, and education.

It should be noted that some of the programs chosen for this report are new, meaning that they were conceived of and/or launched in the past two years, including South Carolina's social marketing campaign, and may have limited outcome measurements in the traditional sense. However, Oral Health America deems all of these programs to be extremely promising. It is gratifying to see new programs that utilize best practice models, go an extra step to integrate new and unusual partners, and address issues in a new light.

Other programs chosen, such as California's fluoridation efforts, have been underway for many years, but significant, new outcomes make them particularly worthy of acknowledgement now.

It is also important to note that not one state in the U.S. is without some momentum towards improved oral health. Some states, such as Ohio, have sustained model oral health programs that are seamlessly addressing all five action steps, and have been for decades—consistently earning the highest grades in Oral Health America's report cards.

There are many star programs in this often marginalized health issue that deserve recognition, and we look forward to highlighting them in future issues of this report.

The theme that emerged [in the development of the *Call to Action*] was that people care about their oral health, are able to articulate the problems they face, and can devise ingenious solutions to resolve them—often through creative partnerships.[4]

4 DHHS, *A National Call to Action to Promote Oral Health*.

A for Effort States

Action 1. Change Perceptions of Oral Health

Many states understand that changing perceptions about oral health is a critical component to building a foundation for change. Washington state, with its Watch Your Mouth campaign, was the first in 2000 to put significant resources, research and energy into creating an environment where proposals to improve oral health are understood and supported by the public and policy makers. The campaign generates media attention and uses advertising to put a spotlight on the problem of oral disease and solutions, and works to enact effective policies. A broad-based coalition actively speaks out and advocates for improved oral health. These efforts, with the tremendous support of the Washington Dental Service Foundation, continue with renewed focus today under the innovative Citizens' Watch for Oral Health policy campaign. A number of states are now following Washington's early lead.

"A" grades go to two states: **Illinois** and **South Carolina**, for developing strategies that raise awareness of oral health's importance to overall health. Both are in the same stage of development, in need of coaxing and monitoring, but are truly exemplary of what this report intends to highlight: effort.

Illinois earns its "A" for passing into law an amendment to the school code mandating that all kindergarteners, second and sixth graders in public, private or parochial schools receive a dental exam. Each child is required to show proof of a dental exam during the school year, or the school may hold the child's report card. Waivers are established for children who show an undue burden or lack of access to a dentist. The law goes into effect in July 2005.

Enforcement for the new standard is limited, given that access is a problem for thousands of children in schools across Illinois, but the law does provide a mechanism for tracking progress and revealing areas of need. Illinois will collect information about the number and percentage of children in each school who have or have not been able to obtain a dental exam. The new requirements will increase awareness of oral health as a critical part of overall health, and promote school-based oral health care as a viable solution. The need for establishing such a policy was first articulated in the Illinois Oral Health Plan (developed with input from community town-hall meetings conducted throughout the state), and then championed by Illinois' grassroots oral health coalition IFLOSS. IFLOSS brought it to the attention of Lieutenant Governor Pat Quinn, and worked with him to promote the mandate. Special recognition is given to the Lieutenant Governor, Illinois State Dental Society, Representative David Miller, and Senator Debbie Halvorsen for their key involvement in the bill's passage.

South Carolina has initiated the development of a comprehensive social marketing campaign on oral health. The "More Smiling Faces" initiative, sponsored by the South Carolina Department of Health and Environmental Control (DHEC), is a social marketing effort to address oral health issues. Social marketing seeks to accomplish social change among a population by using traditional marketing and

[T]here is no one-size-fits-all remedy to the health problems that the nations' communities and populations experience.[5]

5 DHHS, *A National Call to Action to Promote Oral Health*.

advertising methods. To date, it is the first comprehensive attempt by a state health department to design a broad-reaching social marketing campaign around oral health for all age groups.

Research was performed to find out the extent of South Carolinians oral health care knowledge. Focus groups were conducted in three regions of the state to explore residents' knowledge, attitudes and perceptions of issues surrounding oral health. These regions were selected to obtain geographic, racial and socioeconomic representation.

South Carolina has developed a plan with the potential to reach large numbers of state residents with important information on oral health in new and promising ways. Such public information will be critical in curing "the silent epidemic" of oral health diseases.

Extra Credit

Oral Health America acknowledges **Vermont's** on-going social marketing campaign[6] that includes preventive health care messages and ties into its highly successful Tooth Tutor program, a school-based program to meet the needs of underserved children. The state hired a marketing firm to help it find out what parents know about proper oral health care for their children, and the barriers they faced in obtaining it. Vermont ranks among the top states in its coverage of oral health services, dentist participation in Medicaid, and utilization rates by Medicaid eligibles, but despite that, utilization rates are far below Healthy Vermonter 2010 goals. The Vermont Department of Health is addressing a number of issues including lack of consumer education regarding oral health prevention and treatment through a *State Action for Oral Health Access* grant from The Robert Wood Johnson Foundation.

Action 2. Overcome Barriers by Replicating Effective Programs and Proven Efforts

The fluoridation of community water supplies has been listed as one of the ten top public health measures undertaken in the past 100 years. In the absence of a federal mandate ensuring equal access to the documented benefits of fluoridation for all U.S. citizens, states develop individual approaches to accomplishing this goal. **California**, once the laggard in reaching its many residents with fluoridated drinking water, earns an "A" for bringing this proven preventive measure to more than 18 million residents in six counties, overcoming tight budget deficits and local resistance in the process.

A momentous decision was made in February 2003, when the Metropolitan Water District of Southern California (MET) voted to fluoridate its water system, serving the largest customer base in the state. Targeted since 1994 as a key community by the California Fluoridation Task Force, MET moves 1.5 billion gallons of water through its system every day, reaching an area larger than Connecticut and Rhode Island combined. This action will reduce dental caries by 20 to 40 percent in affected communities. Fluoridation is slated to begin in late 2006.

6 More information is available at http://www.chcs.org/publications3960/publications_show.htm?doc_id=237739.

Efforts to fluoridate MET date back to the early 1990s, with the development of the California Fluoridation Task Force, and the passage, in 1995, of a statewide bill requiring retail systems of 10,000 service connections or more to fluoridate if funds are available from an outside source. In 1998, the California Endowment awarded $15 million for this purpose to the Fluoridation 2000 Work Group, including dedicated representatives from the California Department of Health Services, California Dental Association, The Dental Health Foundation, and the County of Los Angeles.

Shortly thereafter, The Dental Health Foundation launched community-based coalitions, reflecting the population served by target water supplies. The coalitions engaged in broad-based education and advocacy with members of the public, including policymakers and water systems boards. Coalitions also met with local editorial staff and reporters, and developed letters to the editor. News coverage and publicized endorsements by community leaders resulted in favorable press coverage in Los Angeles and San Diego.

MET's 2003 decision to fluoridate was triggered by several issues. MET Board leadership championed the cause, and fluoridation was supported by Los Angeles (which fluoridated water supplies in 2000) and San Diego. In addition, by targeting MET, a wholesale water distributor, the emphasis shifted away from water retailers, making the decision more cost efficient and further reaching.

Perhaps the most important aspect of this decision is the fact that it cannot be undone by an ordinance.

Congratulations to the state of California, and the many individuals and organizations that made MET fluoridation possible including: The Dental Health Foundation, LA Citizens for Better Oral Health, San Diego County Water Authority, MET, California Fluoridation Task Force, California Wellness Foundation, California Endowment, CA State Department of Health Services, and the California Dental Association.

Extra Credit

Two states, **New Hampshire** and **Utah** deserve extra credit and recognition for the hard work and tremendous leadership of local fluoridation advocates. These states have repeatedly demonstrated that community coalitions are effective when working together to improve oral health through community water fluoridation.

Manchester and four surrounding communities in **New Hampshire** voted in September 2004 to continue fluoridating their water supply. The measure passed despite nearly five years of debate over a fluoridation referendum in 1999 that adopted community water fluoridation by a slim margin. The high-profile vote attracted a variety of medical experts who spoke at community meetings on behalf of fluoridation—including former U.S. Surgeon General C. Everett Koop. Over the past five years, the debate went to the courts, state legislature, and then back to residents who overwhelmingly supported the decision with a vote of 63-37 percent. The dental hygiene society, Manchester dental society, and pediatricians contributed tremendous amounts of time and energy to this local effort that continues fluoridation for 140,000 residents of the city and surrounding communities.

Utah is an extra credit state for the great leadership of Utahns for Better Dental Health and other fluoridation advocates in Davis County. In November 2004, Davis County voters approved a referendum to keep fluoride in the water, reconfirming their desire for community water fluoridation. Fluoride was the hottest political

topic in the county election as both sides campaigned to persuade voters to keep or remove fluoride from community water supplies. Davis County originally voted to fluoridate in 2000, resulting in a flurry of unsuccessful lawsuits to stop the process. Water systems have been safely fluoridated for the past four years. The Weber Basin Water District, which serves Davis County, reaches 155,000 customers.

Action 3. Build the Science Base and Accelerate Science Transfer

Washington's "A" grade for this action step is in special recognition of the Access to Baby and Child Dentistry (ABCD)[7] model program launched in the mid '90s that is now effectively transferring science to practice – controlling the dental caries (tooth decay) process and reducing the need for costly future restorative work.

ABCD is a collaborative of public and private entities including Washington's Medicaid program, Washington Dental Service Foundation, University of Washington (UW), dental societies and local health departments. Through the commitment of these groups, ABCD is now operating in more than half of Washington's counties.

ABCD has increased the number of dental offices serving as a dental "home" for children aged five and under with Medicaid dental insurance. The dental offices are specially trained by UW Pediatric Dentistry Department in pediatric techniques and preventive services such as fluoride varnishes and oral health counseling. Further, UW plans to update the dental school curriculum to include ABCD techniques so that graduates are automatically certified as ABCD dentists. The Pediatric Dentistry Department is also engaging "dental champions" in each county to take leadership roles in recruiting and training dentists, and schedules advanced courses in restorative techniques and behavior management.

In counties with ABCD programs, almost twice the number of Medicaid-eligible children now receive dental services, mostly due to increases in services to children under two, a population greatly lacking in access to care at the national level.

Researchers at UW are also conducting research on fluoride varnish treatments and plan to utilize those findings to prevent oral disease in young children before it starts.

One recent study conducted by the UW Department of Pediatrics looked at the adoption of fluoride varnish treatments into medical practices, since the state reimburses pediatricians and other pediatric health care providers for applying fluoride varnish to eligible patients' teeth.[8] To accelerate science transfer and further engage primary care medical teams in the delivery of oral health preventive services, an expanded version of ABCD (called ABCD"E") in Spokane County, Kids Get Care in King County, and other efforts across the state have been launched as additional vehicles to prevent children's dental disease.

Extra Credit

Extra credit in building the science base and accelerating science transfer is given not to a state, but to the **United States Army**, which has taken the laudable step of placing xylitol gums in rations (Meals Ready to Eat or MREs) that soldiers eat

7 More information can be found at http://www.abcd-dental.org/.

8 Lewis C, Lynch H, Richardson L. *Fluoride Varnish use in primary care: what do providers think?* Pediatrics. January 2005; 115(1):e69-76.

during deployment and training scenarios. Xylitol is a natural sugar substitute not widely known in the United States that is low in calories and can help prevent tooth decay and recalcify tooth enamel.

Recognizing the need for prevention measures to enhance the soldier's oral health, the U.S. Army Dental Command created "Look for Xylitol First." The program helps educate dental care teams about the positive benefits of this sweetener and teaches patients how to be smart consumers and evaluate products for their xylitol content.[9] In order to ensure that there is enough xylitol in a product to help prevent tooth decay, the Army is encouraging patients to read ingredient lists and look for xylitol as the first ingredient in chewing gums, candies, mints, toothpastes and mouthwashes.

Action 4. Increase Oral Health Workforce Diversity, Capacity, and Flexibility

California earns a second "A" grade this report card for taking a hard look at workforce diversity and dental education in the state through a November 2004 report commissioned by The California Endowment. The report, *Policy Issues in Dental Workforce Diversity and Community-Based Dental Education*, was prepared by the bipartisan National Conference of State Legislatures as a policy and constituency review, and an analysis of strategies for moving policies forward.

To Oral Health America's knowledge, this is the first time that policymakers and state dental school officials have been interviewed to form a comprehensive understanding of leaders' opinions on topics ranging from the supply of dentists, state role in diversifying the workplace, current licensing rules, post graduate residency or training, and dental school recruitment of minorities and rural students.

Regarding the supply of dentists in the state, the report says, "While people acknowledged there are serious access problems, there was no agreement on a shortage of dentists as the cause. Although fully 33 percent of California's dentists are over age 55, and another 31 percent are between the ages of 45 and 54, only one person mentioned an impending shortage." However, interviewees did agree that there is a maldistribution of dentists and a shortage of those who take care of low income and rural populations, special care patients and children.

The report makes clear that the issue of supply and distribution of dentists is not part of routine policy discussions of access problems. Increasing the diversity of the workforce was also not part of interviewees stated organizational policy agendas.

The report concludes that, "While there is broad general support for increasing the diversity of the dental workforce, there is no consensus on the specifics of how to achieve it or if the state should take the lead." Given the lack of consensus, the author is able to make recommendations for six strategies that the state can take to advance community-based dental education and recruitment of minorities. These recommendations include pursuing a pilot project to test a post-graduate year of training for dentists in lieu of a license exam; replicating post-baccalaureate programs (such as the

9 Richter P, Chaffin J. Army's *"Look for Xylitol First" program*. The Dental Assistant, March-April 2004.

University of California at San Francisco's) that have increased acceptance rates for minority students; working with organized dentistry at the state and local level on workforce diversity issues; and focusing on equal opportunity for disadvantaged students, rather than minority recruitment.

Oral Health America commends California for taking on this vitally important issue, and would encourage increased focus by state leaders in order to move beyond discussion and into action.

Extra Credit

Alaska's tremendous challenge in providing access to care for American Indian and Alaska Native populations, especially children, is being addressed in part by the introduction of a new dental team member: the pediatric dental health therapist. For years, countries such as New Zealand and Canada have successfully trained and deployed dental therapists. These professionals are particularly suited to provide cost-effective preventive and restorative care for school children and remote villagers.

The first four of thirteen Alaskan students, sent by the Alaska Native Tribal Health Consortium to train in New Zealand as therapists, returned to Alaska in December 2004 to begin practicing on sovereign tribal lands. The dental therapists will treat children in the context of the Community Health Aide Program, authorized by a federal statute in which Tribes provide primary health care throughout Alaska.

Two major factors contribute to inadequate access to care: the relative geographic isolation of Tribal populations; and the inability to attract dentists to practice in Indian Health Services or Tribal health facilities in rural areas. The dental therapists serve as a new model of care provider for native Alaskan children in remote areas who essentially have no access to oral health care.[10]

Oral Health America congratulates Alaska, especially the Alaska Native Tribal Health Consortium, for seeking innovative, internationally proven models for addressing access issues for underserved children.

Action 5. Increase Collaborations

After the release of *Oral Health in America*, states heeded the call for increased collaborations, and redoubled efforts with the release of the *National Call to Action to Promote Oral Health*. Not one state is without some form of oral health coalition, and advocates recognize that the monumental task of improving the nation's oral health is not possible without traditional and non-traditional partners that can provide resources beyond those of the oral health community. The following examples were chosen in part because of the enthusiasm with which leaders shared their initiatives, and in part because they represent different ways of promoting change: by focusing on policies, awareness, and systems.

Arkansas' relatively new, broad-based oral health coalition, "Smiles: AR, U.S.," has made a concerted effort over the past four years to change the course of the state's trailing oral health grades, earning a place in this *A for Effort* report.

10 Nash D. *Developing and Deploying a New Member of the Dental Team: A Pediatric Oral Health Therapist*. Journal of Public Health Dentistry, 48-55. Vol. 65, No. 1, Winter 2005.

The coalition, made up of 34 agencies, organizations, and corporations, recently helped move the General Assembly to a legislative hearing on fluoridation, and is advocating for the passage of a bill to mandate fluoridation for water supplies with over 5,000 connections. With the Arkansas Office of Oral Health, the coalition also promoted the passage of the only law in the country requiring oral health curriculum in K-12 classes beginning in 2004, and secured a regulatory change allowing dental hygienists to practice under the general supervision of a dentist. The coalition's dedicated, involved membership has sponsored yearly Governor's Oral Health Summits, bringing oral health to the attention of policymakers. In just four years since its creation, this entity is providing ample opportunity for partnerships that work—advancing the state oral health plan (written through the coalition with input from over 200 individuals), and tackling specific, meaningful strategies that improve oral health for Arkansas residents.

New York and **New Jersey** are regional hosts to the Oral Cancer Consortium, a collaboration between dental schools, hospitals, health care institutions, professional societies, and the local media to reduce the incidence of oral cancer and ensure that it is diagnosed early on. The Consortium, conceived in these two states, and now spanning to Pennsylvania, is dedicated to the prevention and early detection of oral cancer.

Oral Health America is awarding "A" grades to the two states for an outstanding grassroots effort that offers a free annual screening, and a consumer web site, www.oral-cancer.org. Moreover, New York is the only state to mandate for dental licensure continuing education in the area of oral cancer detection and prevention.

The Consortium's advertising efforts prompt patients to ask their dentists about oral cancer, and have remarkably increased the number of dentists and health practitioners conducting oral cancer exams. New tools in oral cancer examinations, including brush biopsies enhanced by computer scanning, provide an alternative to surgical biopsies when practitioners find a suspicious site that does not appear to be cancerous or precancerous. A number of cancerous lesions have been identified through Consortium screenings, saving lives and reducing the burden of disease in the region.

When oral cancer is detected early, the five-year survival rate is 80 percent, compared to less than 50 percent if found in later stages. However, only 15 percent of the population reports ever having an oral cancer examination, and just seven percent report having annual screenings. Oral cancer affects over 30,000 people, and claims over 8,000 lives annually, more than cervical cancer or melanoma.

Leaders in **New Mexico** have recognized that a comprehensive approach integrating oral health and community-based primary care is required in order to increase critically needed dental services in rural states and professional shortage areas. In great part due to the tremendous work of the state's dedicated oral health coalition, New Mexico's governor Bill Richardson issued an executive order in November 2004, creating an Oral Health Council, effectively making oral health a priority for state and federal policymakers, advocates, and opinion leaders. Chaired by the state health policy director, the Oral Health Council brings high-level visibility and attention to proposed solutions for challenges in dental care access, prevention, dental education, dentist recruitment and retention, workforce and infrastructure development, school-based health centers, oral

health coverage, and licensing issues, among others. A highly supportive legislature, dedicated oral health champions (such as Senator Jeff Bingaman) and key partners from the public, private, and non-profit sectors all increase the likelihood that changes to New Mexico's oral health care delivery system will have a lasting and profound effect for its citizens.

Extra Credit

Nevada's model Community Coalition for Oral Health of 20+ dedicated organizations state-wide has created a new and rewarding partnership with the Hotel Employees and Restaurant Employees International Union Welfare Fund, a health insurer for over 200,000 of the state's many service employees. The Fund joined the coalition after numerous employees complained about not being able to find a dental care provider that would honor the group's dental plan. As the Fund leaders' knowledge of oral health issues grew, so did their understanding of another basic problem for members. Given seasonal work schedules, seasonal dental coverage for members who would go on and off the plan proved inadequate to provide needed routine care. The Fund faced increasing expenses for more costly procedures that could have been prevented with on-going services. With assistance from the oral health coalition, the Fund is now dedicated to educating employees about oral health, and is further considering coverage of fluoride varnish treatments for employee children. Other Nevada coalition activities include obtaining Medicaid reimbursement for medical professionals to cover fluoride varnishes, efforts to increase Medicaid adult dental benefits, and a critical review of a licensure by credentials issue scheduled to sunset this year.

Partnerships in **West Virginia** are leading to creative solutions to access and utilization problems in this rural state. The West Virginia and Region III Head Start Associations in collaboration with the Office of Maternal, Child and Family Health/Oral Health Program (OHP), West Virginia University (WVU) School of Dentistry, state dental and dental hygiene associations and the Oral Health Task Force recently hosted a forum for 200 dentists encouraging access and utilization for children at an earlier age. A new innovative partnership between OHP, WVU School of Dentistry and the state Extension Service is developing oral health kits for 4-H clubs so that older youth can teach younger children about the importance of oral health. Through 4-H clubs, OHP is conducting a representative survey of youth and parents to learn more knowledge, attitudes, practices and beliefs regarding oral health. This information will help the state improve self-care and to increase utilization of dental services.

In addition, to address the state's high spit tobacco usage rates, the WVU School of Dentistry and multiple partners including the Dept. of Education, Raze (a statewide teen-led, teen-implemented anti-tobacco movement), a synergistic tobacco prevention network, primary care providers (dentists and physicians), Minor and Little League baseball teams, university athletic programs, coaches, and others conduct campaigns to raise awareness of the health risks of spit tobacco use, and to help users quit. Smokeless tobacco use among high school boys statewide showed a decline of 19 percent from 1999 to 2003. The School of Dentistry also participates in West Virginia Rural Health Education Partnerships (WVRHEP) to achieve greater retention of health science graduates in underserved rural areas. Students and rural faculty provide approximately one million dollars of uncompensated care annually through the WVRHEP program.

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Oral Health America is the nation's premier independent organization devoted to oral health. More information is available at www.oralhealthamerica.org.

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